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MEDICAID MANAGEMENT EXCHANGE-MMX

ADMINISTRATIVE NOTES ON MEDICAID MANAGEMENT

CLEARINGHOUSE

JULY 1978 (for administrative use only) ISSUE #3

NEWS IN BRIEF

IMM Conference on Tailoring Health Services to Individual Needs

THE INSTITUTE FOR MEDICAID MANAGEMENT (IMM) is sponsoring a conference for State staff entitled "Tailoring Health Services to Individual Needs," September 25-27 in Dallas, Texas. The conference will address issues arising from deinstitutionalization, and the escalating costs of long term care. Exploration and thought will be given to case management and alternative ways of caring for the elderly, the retarded, and the mentally ill. State staff involved in managing programs for long term care and alternative health delivery systems are urged to attend.

For further information on the conference, contact Ginger Hale at (202) 245-6575, or write:

Institute for Medicaid Management
HCFA/Medicaid Bureau
330 "C" Street, S.W.
Washington, D.C. 20201

California Proposition 13

THE STATE OF CALIFORNIA will take over the county share of Medi-Cal costs for one year, as of July 1, 1978. A surplus spending bill, recently signed by the Governor, was prompted by the passage of Proposition 13, and will provide the counties with fiscal relief, so that other services funded exclusively by local property taxes may be continued.

Wisconsin Prosecutes Medicaid Fraud

A THREE AND ONE-HALF YEAR SENTENCE was handed down by a WISCONSIN judge for a conviction in a case of theft by fraud. A woman, and the school for which she worked, were convicted of stealing more than $100,000 from Medicaid by submitting fraudulent claims for psychotherapy over an eight month period. The judge, in handing down the sentence, cited the seriousness of the crime and the strong need for deterrence in this Wisconsin precedent-setting case.

He pointed out that fraud against society is not a victimless crime, but that people who would benefit from the program, taxpayers, and people who espouse and enact such programs, are all victims. The sentence is particularly significant for a first conviction, white-collar crime, with mitigating circumstances - the woman was pregnant and had a child. The woman was also fined $5,000 and the school $10,000.

Initial information on Wisconsin's efforts to prosecute fraud and abuse was presented through IMM Management and Training Sessions for State Investigators on Medicaid Fraud and Abuse held earlier this year. People interested in reading the decision, or wishing further information on the case, should contact:

Patricia Wright
Institute for Medicaid Management
330 "C" Street, S.W.
Washington, D.C. 20201

MMIS UPDATE

MMIS Status

SEVENTEEN STATES HAVE CERTIFIED Medicaid Management Information Systems (MMIS), and are receiving 75% Federal matching. Newly certified are NORTH CAROLINA and LOUISIANA, both effective July 1, 1977.

TEXAS now has a fully certified MMIS, as the contracted portion was certified effective June 1, 1977. NEW MEXICO re-bid their MMIS and installed a new system, which was certified effective October 1, 1977. ALABAMA, IDAHO, and VIRGINIA had been reviewed but not certified as of July 26; however, certification determinations will be forthcoming.

Other States expected to be reviewed for certification are: CALIFORNIA, KANSAS, NEBRASKA, and NEW YORK.

MMIS Transferred to Alabama

ALABAMA ESTIMATES THAT TRANSFERRING INDIANA'S MMIS to their State resulted in savings of up to $3,000,000, compared to what development costs for a new system would have been.

More important to Alabama was the time saved; the transfer and installation was completed in approximately nine months.

The Indiana MMIS system, developed by Indiana Blue Cross/Blue Shield, has a design that allows for easy transfer. Using their existing eligibility system, Alabama's cost for transferring and modifying Indiana's system was approximately $500,000, according to initial estimates. A HCFA-MMB team visited the Alabama Medicaid agency and Alabama Blue Cross/Blue Shield the week of June 12 to perform an MMIS certification review.

Massachusetts

MASSACHUSETTS HAS FINISHED EVALUATING and ranking bids received on their MMIS development contract. Pilgrim Health Applications, Inc. was ranked highest. Negotiations are now underway between the State and Pilgrim.

New York State MMIS

NEW YORK STATE IS DEVELOPING a Request for Proposal (RFP) for the installation of an MMIS and the processing of claims for the balance of the State outside New York City. It is expected that the contractor will handle more than $1 billion in claims annually.

Iowa Selects Consultec

IOWA'S SELECTION OF CONSULTEC, INC. as an MMIS development contractor has been approved by the Medicaid Bureau. The system will be State owned, but will be installed at the site of Iowa's fiscal agent, Iowa Blue Cross/Blue Shield. Development is expected to take 12 months, with work starting September 1.

MORE NEWS

Medicaid Bureau Eligibility Initiative

ADMINISTRATIVE PROBLEMS IN MEDICAID ELIGIBILITY are the target of a Medicaid Bureau initiative. As part of this effort, Regional and Central Office eligibility staff recently met in Denver to promote uniform application of Medicaid eligibility nationwide. Other "housecleaning" tasks include rewriting the regulations in simpler, clearer language, under project Common Sense, and identifying changes in regulations and law necessary to simplify and streamline Medicaid eligibility policy. In addition, IMM will be scheduling a new series of eligibility workshops in 1979. Inquiries should be addressed to Regional Office eligibility staff.

Rhode Island Increases Medically Needy Levels

RHODE ISLAND'S MEDICALLY NEEDY (MN) LEVEL increased from $3,000 to $3,600 for an individual, and from $4,000 to $4,300 for a couple, effective May 1, 1978. This raise will allow some people who might have been dropped because of Social Security increases to stay in the program. The new MN limit for a family of four is $6,100.

Common Billing Forms

CONNECTICUT RECEIVED APPROVAL to become the first official test site for UB-16, a proposed uniform hospital billing form. Final approval will come after acceptance of the form by 80% of the hospitals in the State. This action paves the way for ARIZONA to proceed with its plans to use the form. The UB-16 is being developed by representatives from the American Hospital Association, Medicare, Medicaid, the Health Insurance Association of America, National Blue Cross and State hospital associations.

Nine of 44 State Medicaid agencies are now using the AMA universal billing form for physicians, according to a Medicaid Bureau survey. ARKANSAS Medicaid will begin use of the AMA form August 1, to become the tenth State. In Arkansas, the form is already used by Medicare, and Blue Shield. New Mexico plans to implement a modified version of the AMA form January 1, 1979, to be used by Medicaid, Medicare, Blue Cross and Equitable Insurance.

A uniform hospital billing form has been adopted by Medicaid and Medicare in NORTH CAROLINA. The State Medicaid agency has also proposed adoption of a uniform physician billing form, providing the form contains all data elements required for MMIS certification.

PERSONNEL

RICHARD W. HEIM was officially sworn in as Director of the Medicaid Bureau (MMB) June 27. PAUL R. WILLGING, who was the interim Acting Director, is now Deputy Director of MMB.

ARTHUR J. O'LEARY has been appointed Regional Medicaid Director for Region II.

New Single State Agency Heads:

JOHN A. BEARE, M.D. is the new single State agency head in WASHINGTON STATE. The State has redesignated the Health Services Division as the new single State agency, replacing the Department of Social and Health Services.
MS. BEVERLEE MYERS was appointed Director of the Department of Health Services in CALIFORNIA, to become the new single State agency head in that State.

New Medical Assistance Unit Heads:

Mr. Rod Petit — Alaska
Mr. Peter B. Coppola — Dist. of Col.
Mrs. Bonnie Smith — Louisiana
Mr. David Williams — Maine
Mr. Paul M. Allen — Michigan

Eligibility Workers in Hospitals

IN A PROGRAM DESIGNED to gather better recipient information, TEXAS is assigning Medicaid eligibility workers to major hospitals in the State. This will allow for prompt verification of eligibility of hospitalized recipients, and help smooth the flow of crossover claims. Ready access to eligibility information will cut costs by reducing erroneous billings. In addition, the eligibility workers will assist in referring recipients to other services. Hospitals with on-site eligibility workers will fund 50% of the salaries, and provide office space and certain other items at no cost to the State.

Decrease in Medicaid Recipients

THE NUMBER OF MEDICAID RECIPIENTS DECLINED in FY 1977 for the first time since the beginning of the program, according to HCFA Research Report B-5. The average monthly Medicaid caseload decreased 1.1%, from 9,139,000 in FY 1976 to 9,037,000 in FY 1977. The number of disabled recipients increased 6.2% over the same period.

The report projects that the unduplicated annual count of recipients decreased 3.2%, to an annual figure of 23,835,000 over the same period. Total payments in FY 1977 increased 14.1% over FY 1976. However, the definition of Fiscal Year changed between FY 1976 and FY 1977, with the closing date moving from June 30 to September 30. Compared to the equivalent time period a year earlier, FY 1977 payments increased 9.8%. FY 1977 also showed a 20% growth over FY 1976 in the consumer price index medical care component.

Total Medicaid payments in FY 1977 were $16.3 billion. Payments for ICFs in FY 1977 increased 28.9% over FY 1976. Hospital payments increased 13.5%, physician payments 8.4%, SNF payments 8.0%, drug payments 6.0%, and dental payments 3.4%. This is the first time in six years that increases in physician and drug payments have been held under 10%, and the first year in five that dental payments increased less than 10%.

The B-5 report is compiled from data reported by States on the Federal Report Form HCFA-120: Monthly Statistical Report on Medical Care.

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MQC Corrective Action

IN ADDITION TO IMM'S TECHNICAL ASSISTANCE effort, a task force is being developed to help States reduce MQC error rates. It's called the CORRECTIVE ACTION PROJECT (CAP), and will offer about 30 staff who can assist individual States in MQC related program areas such as eligibility and claims processing management and third-party benefit recovery.

CAP staff are available for on-site field work to implement operational improvement projects tailored to the needs and capabilities of each State. They can also arrange to contract for more intensive or specialized technical assistance when needed. Some CAP State projects might include:

- development and use of error-prone client profiles for better caseload management;
- client and caseworker accountability (e.g., performance standards for caseworkers, client reporting and verification methods);
- improvement of forms and policy instructions for caseworkers;
- establishing or expanding cost-effective third-party benefit recovery operations;
- better use of data exchange sources (SDX, BENDEX, etc.); and
- analysis of State claims payment edits for eligibility, third-party benefits, duplicate and over-payments, and problem solving to ease transition from one claims process to MMIS.

State requests for CAP assistance should be directed to Mary Kenesson (202) 472-2781, or write:

Medicaid Corrective Action Project
Room 1319, Mary E. Switzer Building
330 "C" Street, S.W.
Washington, D.C. 20201

THE HOUSE WAYS AND MEANS COMMITTEE (Ullman, D-OR, chmn.) reported out HR 10909, the Clinical Laboratory Improvement Act, July 12. The bill, in order to become law, must still pass on the floor of the House and be reconciled with the Senate version, S 705, in a conference committee, and be signed by the President. The bill tightens regulation of private clinical labs and reforms Medicaid lab reimbursement practices. (See MMX #1 for details.)

CHAP

HR 6706, THE CHILD HEALTH ASSESSMENT ACT (CHAP) has been reported out of Congressman Paul Rogers' (D-FL) Subcommittee on Health and the Environment. Most earlier decisions made on the bill were ratified at the final mark-up session, including setting a nationwide minimum income standard of $4,200 for a family of four, increasing the Federal match for children under case management, and expanding dental and ambulatory mental health coverage for children. (See MMX #1.)

Additional amendments to the bill tightened performance standards applicable to States by making clear that such standards must apply to children actually assessed and treated, rather than to requests and referrals, and deleted the time limitation on the increased match (75%) for outreach services.

Another amendment permits Medicaid coverage of children (under 18) in public institutions or facilities, except adult prisons, if such children would otherwise be eligible for Medicaid. Also, unrelated amendments were passed which would protect Medicaid eligibility for those who would lose it through increases in VA or Railroad Retirement pensions, and which would clarify "residency" requirements to include migrants (and their families) who are in a State for the purpose of seeking employment.

The full House Interstate and Foreign Commerce Committee (Staggers, D-WV, chmn.) will begin CHAP mark-up August 1.

S 1470 (Talmadge Bill)

ON JULY 21, THE SENATE FINANCE COMMITTEE (Talmadge, D-GA, chmn.) held an initial mark-up session on S 1470, the Medicare and Medicaid Administrative and Reimbursement Reform Act. The Committee made a number of modifications to the bill, as well as agreeing to a number of the bill's provisions. Further mark-up is scheduled for the beginning of August.

The Committee tentatively approved an amendment that would modify the method of reimbursement for hospitals under Medicare and Medicaid so that most of a hospital's routine inpatient costs would be subject to a target rate based on costs incurred by comparable hospitals. Those hospitals with below average costs would receive incentive payments, while payments to hospitals with substantially above average costs would be reduced.

Some of the other provisions included in the bill: Medicare and Medicaid reimbursement would be allowed for swing-beds in rural hospitals with less than 50 beds; States would be given the option of including reasonable incentive payments in Medicaid SNF and ICF payments rates; the certification function for Medicare and Medicaid SNFs and ICFs would be unified, by making HEW responsible for Medicaid only SNFs and ICFs. This means that the Medicare certification process would apply to all nursing homes. Agreements would be time limited (not to exceed 12 months). Also, aged, blind, disabled, and individuals would be denied Medicaid benefits for a year if they disposed of their assets to any person at substantially less than fair market value.

GAO Report on Lab Contracting

WORTHWHILE SAVINGS ARE AVAILABLE to the Medicaid program through competitive procurement of supplies and laboratory tests, according to a recent General Accounting Office (GAO) report. The report, entitled "Savings Available by Contracting for Medicaid Supplies and Laboratory Services," found that competitively awarded contract prices for eyeglasses were 46% lower in WASHINGTON STATE than prices charged in CALIFORNIA, and the price for oxygen in Washington was 40% lower than in OREGON. If NEW YORK CITY Medicaid had paid the same price for lab tests as the New York City Family Planning Agency (a volume purchaser), savings of 30-70% could have been realized.

Current HEW policy is that recipient "freedom of choice" must exist with providers, but need not exist with suppliers of providers. This allows for the mass purchase of eyeglass lenses and frames, and under certain conditions, drugs, to be dispensed by the physician of choice. However, "sole source" contracts with laboratories are against Federal law.

To better assure that States purchase Medicaid supplies at the lowest possible price, GAO also recommended that Congress authorize competitive procurement of lab services on an experimental basis, limit Medicaid lab payments to the lowest charge available to other purchasers for comparable services, and (to clarify freedom-of-choice issues) grant the Secretary of HEW authority to exclude eyeglasses, hearing aids, oxygen and common durable medical equipment from the freedom-of-choice provision.

Single copies of the complete report (#HRD-77-70) are available without charge from:

U.S. General Accounting Office
Distribution Section, Room 1518
441 "G" Street, N.W.
Washington, D.C. 20548

New Jersey Institutes 1CF/MR Program

NEW JERSEY IS NOW COVERING Intermediate Care Facilities for the Mentally Retarded under Medicaid. The program, instituted October 1, 1977, is expected to cost $84,000,000 a year by FY 1979, and increase New Jersey's program expenditures 12.3%.

National Health Plan

IN ANNOUNCING PRINCIPLES FOR A NATIONAL HEALTH PLAN July 29, HEW Secretary Joseph A. Califano stressed the need to address the critical problem of health care inflation and provide all Americans with coverage for basic services and protection from catastrophic expenses. In a directive to the Secretary, President Carter declared he would not support any health care plan which was inflationary.

The principles released by Califano stated that any plan must: eliminate substandard care for the poor; assure freedom of choice in selection of providers; include aggressive cost-containment measures; be phased in gradually; be financed through multiple sources, including contributions from employers and employees; promote major reforms in the delivery of health care services and improve the efficiency of the health care system; include a significant role for the private insurance industry; and assure consumer representation throughout.

The current timetable calls for HEW to make public by the end of the year a tentative plan which embodies these principles, and which will serve as a basis for in-depth consultation with other groups. Detailed recommendations will be made to the President early in 1979, when he will make final decisions on the shape of legislation. Carter has asked that the Plan call for no additional spending until FY 1983 because of budget constraints and the need for careful planning.

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OCH Pushes Test for Lead Poisoning

THE OFFICE OF CHILD HEALTH (OCH), Medicaid Bureau, strongly recommends that States use the EP test to screen for lead poisoning in all children ages 1 through 5. The erythrocyte protoporphyrin (EP) test represents an advance in screening technology that allows for a quick, simple and inexpensive test to determine undue lead absorption. The test screens for iron deficiency as well.

OCH now recommends that the EP test be part of all EPSDT screens for those children aged 1 through 5, since large scale screening studies of children without symptoms have demonstrated that the problem is far more widespread than previously thought. Three to 20% of children tested in both urban and rural areas had undue lead absorption. Excessive lead exposure, which can only be determined by laboratory analysis, has serious and largely irreversible effects on the central nervous system.

MMB has distributed AT-78-59, which gives further details, and Preventing Lead Poisoning in Young Children (April 1978), a statement on lead poisoning by the Center for Disease Control, to State agencies and Regional offices. A wider distribution of the latter will occur in September.

Additional copies of the statement are available from:

Environmental Health Services Division
Center for Disease Control
Atlanta, Georgia 30333

Pennsylvania Hospital Cost Containment

INCREASES IN INTERIM PER DIEM HOSPITAL RATES for Medicaid patients will be limited to 12% a year, under a cost containment plan recently announced by PENNSYLVANIA Public Welfare Secretary, Aldo Colautti. Effective July 1, the plan also places hospitals with 100 or more beds under a maximum reasonable cost formula, which allows for increases based on the rate of inflation in the general economy. The formula will be applied to the hospital's actual costs, as determined by the Auditor General. The plan is currently being reviewed by HEW.

Nine States Have Certified Fraud Units

SEVEN ADDITIONAL STATE Fraud and Abuse control units were given Federal certification to receive 90% matching under the provisions of 95-142. They are: NEW MEXICO, MICHIGAN, CONNECTICUT, RHODE ISLAND, COLORADO, WASHINGTON, and NEW JERSEY. LOUISIANA and ALABAMA were certified previously. (See MMX #2)

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Marc Wilhelm

editorial inquiries:

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UPCOMING
IMM EVENTS

Kansas Drug Reimbursement Conference

THE KANSAS PHARMACISTS ASSOCIATION is sponoring a seminar on the Kansas variable fee system of reimbursing pharmacists for Medicaid prescriptions. The seminar will be held September 13-14 at the Hilton Airport Plaza Inn, Kansas City, Missouri. The registration fee is $125 per participant. In addition, participants are responsible for their own meals and lodging.

Vince Gardner, Director, Office of Pharmaceutical Reimbursement, and Henry Spiegelblatt, Director, Division of Policy and Standards, both from the Medicaid Bureau, will be making presentations at the meeting. To register, and for further information, write:

Kansas Pharmacists Association
1308 W. 10th Street
Topeka, Kansas 66604

State Medicaid Management Review Workshop (for Regional and Central Office Staff)

San Antonio 9/12-14

Tailoring Health Services to Individual Needs Conference for States

Dallas 9/25-27

Workshop for Federal and State Training Staff in the Use of "Orientation to Medicaid: A Federal Perspective"

Richmond, Va. 9/24-28

Estes Park, Co. 10/22-26

Please contact the Institute for Medicaid Management for further information.

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